DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 10140 (10/04)

STATE OF WISCONSIN
WI. Stats s. 49.47

WISCONSIN MEDICAID FOR ELDERLY, BLIND AND DISABLED SUPPLEMENT TO FOODSHARE WISCONSIN APPLICATION

Providing or applying for a Social Security Number (SSN) is voluntary; however, any person who wants Wisconsin Medicaid or FoodShare benefits but does not provide an SSN or apply for one will not be eligible for benefits. SSNs and personally identifiable information will be used only for the direct administration of Medicaid and FoodShare Wisconsin.

This form is used as a supplement to the FoodShare Wisconsin Application. Complete this form only if you are applying for FoodShare Wisconsin and Medicaid. If additional space is needed, use an additional sheet of paper. List the applicant as "1" and, if married, the applicant's spouse as "2". (When completing the rest of the application, continue to use the same format with information for the applicant as "1" and, if married, the applicant's spouse information as "2".) Write all dates in the MM/DD/YY format (Example 04/02/58).

SECTION I – APPLICANT INFORMATION

Applicant Name (Last, First, MI)	Applicant Address (Street, City, State, Zip Code)

SECTION II – VEHICLE INFORMATION

List all vehicles owned by applicant(s). Include vehicles owned jointly with another person.

	Type of Vehicle	Year, Make and Model of Vehicle	Name of the Owner(s)	Amount Owed (If nothing is owed, list "0".)	Is this vehicle used to get to medical appointments?	Is this vehicle used for employment, training, school or farming?
1				$	☐ Yes ☐ No	☐ Yes ☐ No
2				$	☐ Yes ☐ No	☐ Yes ☐ No

SECTION III – MEDICAL INSURANCE INFORMATION

Do you and/or your spouse have medical insurance coverage (other than Medicaid)? ☐ Yes ☐ No If "Yes", complete the following information.

	Date Coverage Began	Premium Amount	How often is premium paid?	Who pays the premium?	Name of Policyholder	Who is covered?	Insurance Name and Address	Policy Number
1		$						
2		$						

Are you and/or your spouse covered by the Wisconsin Health Insurance Risk Sharing Plan? ☐ Yes ☐ No
If "Yes", who is covered?

Have you and / or your spouse incurred medical bills as a result of an accident or do either of you have an accident claim or settlement pending?
☐ Yes ☐ No If "Yes", check below if you and/or your spouse have incurred bills or have a claim or settlement pending.

1	☐ Incurred Bills ☐ Claim or Settlement Pending	**2**	☐ Incurred Bills ☐ Claim or Settlement Pending

Are you and / or your spouse receiving Medicare Part A or B? ☐ Yes ☐ No If "Yes", list the Medicare Card Number (claim number) below.

1		**2**	

If eligible, would you and / or your spouse like the State of Wisconsin to pay your Medicare Part B premium? ☐ Yes ☐ No

SECTION IV – RESOURCE TRANSFER

Have you sold or given away resources or assets in the last three years? ☐ Yes ☐ No
If "Yes", list the type of resource or asset, value and the date it was sold or given away below.

	Type of Resource or Asset	Date Sold or Given Away	Amount $	Type of Resource or Asset	Date Sold or Given Away	Amount $
1						
2						

Have you and / or your spouse set up or funded a trust in the last five years? ☐ Yes ☐ No If "Yes", complete the following information.

	Type of Trust	Date Trust Was Funded	Type of Trust	Date Trust Was Funded
1				
2				

Are you and / or your spouse in a nursing home, institute for mental disease (IMD) or a hospital? ☐ Yes ☐ No If "Yes", complete the following information.

	Name or Person in a Nursing Home, IMD or Hospital	Name of the Nursing Home, IMD or Hospital	Date of Admission to Each Nursing Home, IMD or Hospital?
1			
2			

SECTION V – RIGHTS AND RESPONSIBILITIES

Your signature on the application means that you understand and acknowledge that the county/tribal social or human services agency, W-2 agency and the state Department of Health and Family Services is authorized to request any information that is appropriate and necessary for the proper administration of the Medicaid programs authorized under Wisconsin law. Any persons, including financial institutions, credit reporting agencies, or educational institutions are authorized to release this information unless it is prohibited or restricted by law.

If you are found eligible for Medicaid, Wisconsin State law, with limited exceptions, requires the recovery of certain Medicaid benefits from your estate. The "Estate Recovery Program" brochure (PHC 13032) provides you with information on estate recovery. You may obtain a copy of the brochure from your local county/tribal social or human services agency, or by contacting Recipient Services at 1-800-362-3002. Certain benefits you receive in the community after age 55 and all Medicaid benefits you receive while residing in a nursing home or while you are an inpatient in a hospital for 30 days or more, are recoverable. Also, if you reside in a nursing home or are institutionalized in a hospital, and are not expected to return home to live, a lien may be placed on your home. A lien may not be placed on your home if you, your spouse, or certain other family members reside in the home.

You have the right to an appeal by requesting a Fair Hearing if you do not agree with any action taken concerning your application or ongoing benefits. You may request a Fair Hearing, by calling 1-608-266-7709, or writing to:

Wisconsin Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

You may also contact the county/tribal social or human services agency and ask for a fair hearing verbally or in writing. DHFS is an equal service provider. To file a complaint of discrimination, contact:

Wisconsin Department of Health and Family Services
Affirmative Action and Civil Rights Compliance Office
1 West Wilson Street, Room 555
Madison, WI 53707-7850
Telephone: 1-608-266-9372 (voice) or 1-608-266-2555 (TTY)
Fax: 1-608-267-2147

Or

U.S. Department of Health and Human Services
Office of Civil Rights – Region V
233 N. Michigan Avenue Suite 240
Chicago, IL 60601
Telephone: 1-312-886-2359 (voice) or 1-312-353-5693 (TTY)

Please read the Rights and Responsibilities above before signing.

I understand the questions and statements on this application form. I understand the penalties for giving false information or breaking the rules. I certify, under penalty of perjury and false swearing, that all my answers are correct and complete to the best of my knowledge, including information provided about the citizenship or immigration status of each household member, applying for benefits. I understand and agree to provide documents to prove what I have said. I understand that the agency may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits. (The applicant's signature must be witnessed by two people if signed with an "x".)

SIGNATURE – Applicant / Representative / Guardian / Power of Attorney / Conservator	Date Signed
SIGNATURE – Spouse / Representative / Guardian / Power of Attorney / Conservator	Date Signed
SIGNATURE – Witness (Needed if Application Signed with an "X" above)	Date Signed
SIGNATURE – Witness (Needed if Application Signed with an "X" above)	Date Signed

RESET FORM